

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>EASTON, RURAL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>EASTON RURAL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>DIAMONDS CORNER</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>EDWARD</u> (Middle) <u>COLUMBUS</u> (Last) <u>BENTLY</u>	4. DATE OF DEATH	(Month) <u>JAN.</u> (Day) <u>17</u> (Year) <u>1951</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC. 10, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	9. AGE last birthday <u>61</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>HOWARD BENTLY</u>	14. MOTHER'S MAIDEN NAME <u>EMILY LAWRENCE</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u>	16. SOCIAL SECURITY No. <u>WWT 057-22-1832</u>	17. INFORMANT AND ADDRESS <u>BEATRICE BENTLY, EASTON, R.D.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Cardio-Vascular Disease(c) Hypertension

INTERVAL BETWEEN ONSET AND DEATH

4 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION

None

19b. MAJOR FINDINGS OF OPERATION

None

21. ACCIDENT

(Specify)

SUICIDE

No

HOMICIDE

No

TIME (Month) (Day) (Year) (Hour)

None

OF INJURY

None

PLACE (Home, farm, factory, street, OF office bldg., etc.)

INJURY

No

INJURY OCCURRED

While at

Work

Not While

At work

X

X

(CITY OR TOWN)

None

(COUNTY)

None

20. AUTOPSY?

Yes ☐ No ☒

22. I hereby certify that I attended the deceased from Nov 2, 1947, to Jan. 17, 1951, that I last saw the deceased

alive on

SIGNATURE

19

and that death occurred at

(Degree or title)

M.D.

ADDRESS

St. Michaels, Maryland

DATE SIGNED

1.19.51

23. BURIAL, CREMATION REMOVAL (Specify)

BURIAL

DATE THEREOF

20 JAN 1951

NAME OF CEMETERY OR CREMATORY

ST. PAUL'S CEMETERY

LOCATION (City, town, or county)

EASTON, R.D. MD.

(State)

DATE REC'D BY LOCAL REG.

1/18/51

REGISTRAR'S SIGNATURE

N.H. Neer

24. FUNERAL DIRECTOR

JOHN D. WILLIAMS, EASTON, MD.

ADDRESS

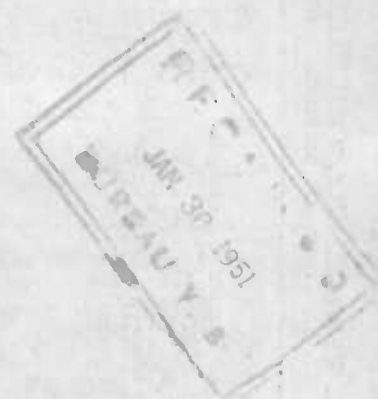
100105

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0873

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Edm</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester town</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Yetta</u>	(Middle) <u>Dahne</u>	(Last) <u>Bennett</u>
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>25</u> (Year) <u>1957</u>
8. DATE OF BIRTH <u>Sept. 15, 1894</u>	9. AGE last birthday <u>56</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Russia</u>	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Nathaniel Dahne</u>	14. MOTHER'S MAIDEN NAME <u>Rachel</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.	17. INFORMANT <u>Benjamin B. Bennett</u>		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary occlusion</u>		<u>1 hour +</u>
940 Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE (Degree or title) Lois Q. Mott ADDRESS Easton Md DATE SIGNED 1-26-57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>1-28-57</u>	NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>	LOCATION (City, town, or county) <u>Balto Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>1/26/57</u>	REGISTRAR'S SIGNATURE <u>N.A. Neerues</u>	24. FUNERAL DIRECTOR <u>Jack Lewis</u>	ADDRESS <u>2100 Burton Pl</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 7 1961
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Rural, Drytown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lathe</u>	(Middle) <u>S.</u>	(Last) <u>Brise</u>
4. DATE OF DEATH	(Month) <u>Jan.</u>	(Day) <u>29</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 1-1886</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>on farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Willey</u>		14. MOTHER'S MAIDEN NAME <u>Charolette Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT AND ADDRESS <u>Laurence Willey, Easton, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

T.B. of Spine

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6/1, 1950, to 1-29, 1951, that I last saw the deceasedalive on 1-28, 1951, and that death occurred at 3:50 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

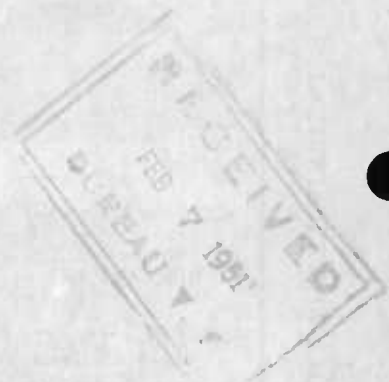
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb. 1-1951</u>	<u>Queen Esther Church</u>	<u>Drytown</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/28/51</u>	<u>N.A. Morris</u>	<u>John D. Williams</u>	<u>Easton, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

720826



0875

290

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 290

1. PLACE OF DEATH— COUNTY <u>Talbot</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> LENGTH OF STAY (In this place) <u>40 min</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>MD</u> COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John</u> <u>Butler</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan</u> <u>27</u> <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept 10 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer - gas pump - farm helper</u>		9. AGE last birthday If under 1 year Months Days Hours Min. <u>41</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>John Henry Dickson</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Mar Butler</u>	
16. SOCIAL SECURITY No.		17. INFORMANT <u>Mary E. Butler</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause <u>331x Cerebral hemorrhage</u>		(a)			
Antecedent cause(s) <u>83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		(b)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>.					
SIGNATURE <u>Louis (Marty) M. D. M.D.</u>		ADDRESS <u>Easton Md</u>		DATE SIGNED <u>1-27-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1/29/51</u>		NAME OF CEMETERY OR CREMATORY <u>Chapel</u>	
LOCATION (City, town, or county) (State) <u>Chapel Md</u>		24. FUNERAL DIRECTOR <u>Norman W. Moushree</u>			
DATE REC'D BY LOCAL REG. <u>1/29/51</u>		REGISTRAR'S SIGNATURE <u>N. D. Neer</u>			

970116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 7 1951
READ V. P.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for addition
in #18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0876

FILM No. G 130 JAN 29 1957 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>R.F.D. Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Belleme R.F.D. Easton Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home Belleme Md.</u>		STREET ADDRESS (If rural, give location) <u>none</u>	
3. NAME OF DECEASED (Type or Print) <u>Richard</u> (First) <u>Henry</u> (Middle) <u>Cook</u> (Last)		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>10</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 13-1867</u>
9. AGE last birthday <u>83</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer on farm</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Talbot Co, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Richard Cook</u>	
14. MOTHER'S MAIDEN NAME <u>Ethel Mackey</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT <u>William Cook</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause <u>177x Carcinoma of the prostate gland</u>	(a) <u>La grippe</u>	INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>
Antecedent cause(s) <u>51x Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>	(b) <u>La grippe</u>	<u>1 week</u>
(c) <u>La grippe</u>		

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. <u>La grippe</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>(1/29/51 akc)</u>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1957, to Jan 10, 1957, that I last saw the deceased

alive on Jan 10, 1957, and that death occurred at 4 A.M., from the causes and on the date stated above.

SIGNATURE Hayward T. Webb, M.D. ADDRESS Jan. 12/51 DATE SIGNED Webb

23. BURIAL, CREMATION, REMOVAL (Specify) <u>11/13/57</u>	DATE THEREOF	NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>	LOCATION (City, town, or county) <u>Belleme</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>1/13/57</u>	REGISTRAR'S SIGNATURE <u>N.H. Nevers</u>	24. FUNERAL DIRECTOR <u>Leon W. Henry Easton</u>	ADDRESS	

820105

VS. A15

RECEIVED
U.S. DEPARTMENT OF DEATH

RECEIVED
JAN 23 1961
U.S. DEPARTMENT OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>EASTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PRESTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EASTON Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Augusta</u> (Middle) (Last) <u>Yadow</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 26 1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 12, 1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>NW</u>	9. AGE last birthday <u>84</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Schroder</u>		14. MOTHER'S MAIDEN NAME <u>Widow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mr Ernest Yadow</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
561.3 Immediate cause (a) <u>Intestinal obstruction</u>	<u>24 hrs</u>
Antecedent cause(s) (b) <u>Hernia, ventral, Post-operative</u>	<u>4 yrs</u>
122a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-25, 1951, to 1-26, 1951, that I last saw the deceased alive on 1-26, 1951, and that death occurred at 3:35 p.m., from the causes and on the date stated above.

SIGNATURE J. H. Noble, MD (Degree or title) ADDRESS St. M. Noble - Preston, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	<u>1/29/51</u>	<u>St. M. Noble - Preston, Md.</u>		
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/26/51</u>	<u>J. H. Noble</u>	<u>St. M. Noble - Preston, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 7 1951
BUREAU V. S.

1187:1

290

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1/24/51	Dilgman M.S. Church	Dilgman	Ind
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
1/22/51	M.H. Neerue	Eds more	Dilgman	

VS. A15A

RECEIVED
JAN 30 1951
U.S. DEPT. OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland.</u> COUNTY <u>Car.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital.</u>		STREET ADDRESS (If rural, give location) <u>Park Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Marie</u> (Middle) (Last) <u>Hasper.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 15 1911</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug. 13, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>26</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Coulbourne</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pratts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Releg Pratts</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Peritonitis</u>		<u>48 hrs.</u>
(b) Antecedent cause(s) <u>Disruption of gastroenterotomy done 540.0 117a</u>		<u>48 hrs.</u>
(c) <u>Gastroenterotomy for stenosing ulcer 7 days</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>1/9/51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Complete obstruction of pylorus from ulcer</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/4, 1951, to 1/15, 1951, that I last saw the deceased alive on 1/14, 1951, and that death occurred at 3:45 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Jan. 18 1951</u>	<u>Mt. Zion Cemetery</u>	<u>Wilmington, Del.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/16/51</u>	<u>N.H. Neerue</u>	<u>Charles H. Gray Funeral Home</u>	<u>722 Walnut St. Wilmington, Del.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Bellet</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton Md</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Bellet</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> STREET ADDRESS (If rural, give location) <u>Quora Street</u>	
3. NAME OF DECEASED (Type or Print) <u>William L. Borden</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 28, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Religious Training</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious Training</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mr. William L. Borden</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Armstrong</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT AND ADDRESS <u>Miss Eleanor Borden</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 Immediate cause

(a) Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

7 years

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) _____

(c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Cerebral Arteriosclerosis

years

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1/17, 1951, to 1/26, 1951, that I last saw the deceased

alive on 1/25, 1951, and that death occurred at 2:20 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>		<u>1/29/51</u>	<u>Spring Hill</u>	<u>Easton</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>1/27/51</u>		<u>N.A. Neerue</u>	<u>John A. Hallinan</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

106105

RECEIVED
FEB 7 1951
BUREAU Y. C.

Evidence for addition
on #8 & #9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

FILE No. G 130 JAN 26 1951

1. PLACE OF DEATH - COUNTY <u>2nd Nat</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
TOWN <u>Easton</u>		TOWN <u>Denton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>—</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Mellie</u> (Middle) <u>Jessie</u> (Last) <u>Jenkins</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>about 1898</u>
9. AGE last birthday <u>53</u> yrs. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. FATHER'S NAME <u>Mr. Roy Davidson</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If year, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Katie Carroll</u>	
15. SOCIAL SECURITY No. <u>unknown</u>		17. INFORMANT <u>Mr. Wm. Jenkins - Husband</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>592x</u> <u>Memix - due to chronic glaucoma & nephritis</u>			<u>(?)</u>
Antecedent cause(s) (b) <u>131b</u> <u>Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last</u>			
II. OTHER SIGNIFICANT CONDITIONS (c) <u>—</u>			
Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>—</u> SUICIDE <u>—</u> HOMICIDE <u>—</u>		PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>—</u> INJURY <u>—</u>		(CITY OR TOWN) <u>—</u> (COUNTY) <u>—</u> (STATE) <u>—</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		INJURY OCCURRED While at <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>—</u>	

22. I hereby certify that I attended the deceased from 3/1/51, 1950, to 1/1/51, 1951, that I last saw the deceased alive on 3/1/51, 1950, and that death occurred at 1:20 am., from the causes and on the date stated above.

SIGNATURE (Degree or title) H. C. Carson, Maryland ADDRESS 1/1/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		DATE <u>Jan 3, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Denton</u>	LOCATION (City, town, or county) <u>Denton, Ind</u>	(State) <u>Ind</u>
DATE REC'D BY LOCAL REG. <u>1/2/51</u>		REGISTRAR'S SIGNATURE <u>N. H. Neerues</u>	24. FUNERAL DIRECTOR <u>J. V. Moore</u>		ADDRESS <u>Denton, Ind</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>Queen Annes</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>	
TOWN <u>EASTON</u>		TOWN <u>Church Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EASTON Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Hilida</u> (Middle) <u>Kennedy</u> (Last) <u>Kennedy</u>		4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Jan 15, 1909</u>
9. AGE last birthday <u>41</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>NW</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Telghman</u>		14. MOTHER'S MAIDEN NAME <u>Stella Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT <u>Lee Stanbury</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Lymphatic Leukemia Acute</u>				<u>1 week?</u>	
Antecedent cause(s) (b) <u>74a</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 12/31, 1950, to 1-1, 1951, that I last saw the deceased alive on Jan 1, 1951, and that death occurred at 3:45 pm, from the causes and on the date stated above.

SIGNATURE <u>B. C. Coe</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>Easton Md</u>		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE <u>1/4/51</u>		NAME OF CEMETERY OR CREMATORY <u>Salmon</u>		LOCATION (City, town, or county) (State) <u>Starky's Grove, Md</u>	
DATE REC'D BY LOCAL REG. <u>1/2/51</u>		REGISTRAR'S SIGNATURE <u>N.D. Meeres</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill</u>	

720826 md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1961 82 NW

1961 82 NW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Calbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS <u>—</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Mr. Frederick</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>Oct. 25, 1876</u>	
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Mr. Frank Kessler</u>		14. MOTHER'S MAIDEN NAME <u>Irenia Brombeis</u>	
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT <u>Mrs. Gertrude Kessler - wife</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Perforated peptic ulcer</u>		<u>48 hrs</u>	
Antecedent cause(s) (b) <u>Adeno carcinoma of the bladder</u>		<u>49 years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Adeno carcinoma of the bladder</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 30 Dec, 1950, to 1 Jan, 1951, that I last saw the deceased alive on Jan 1, 1951, and that death occurred at 7:45 A m., from the causes and on the date stated above.

SIGNATURE Thos. H. Harrison ADDRESS Dr. H. Harrison, 1400 N. Charles St., Baltimore DATE SIGNED Jan 5/51

23. BURIAL CREMATION REMOVAL (Specify) <u>Cremation</u>		DATE <u>1/3/51</u>		NAME OF CEMETERY OR CREMATORY <u>Silverbrook</u>		LOCATION (City, town, or county) <u>Wilmington Del</u>	
DATE REC'D BY LOCAL REG. <u>1/2/51</u>		REGISTRAR'S SIGNATURE <u>M.H. Neer</u>		24. FUNERAL DIRECTOR <u>R.B. Rawlings</u>		ADDRESS <u>Wilmington Del</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <i>Talbot County</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Talbot</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Easton</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Cordova</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Easton Memorial Hosp.</i>		STREET ADDRESS (If rural, give location) <i>none</i>	
3. NAME OF DECEASED (Type or Print) <i>Mrs. Edna</i>		4. DATE OF DEATH (First) <i>Jan.</i> (Month) <i>7</i> (Day) <i>1951</i> (Year)	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>		8. DATE OF BIRTH <i>Nov-18, 1884</i>	
9. AGE last birthday <i>66</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Mr James Wood</i>		14. MOTHER'S MAIDEN NAME <i>Laura Flourez</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>Unknown</i>	
17. INFORMANT <i>Mrs Ethel Gallagher</i>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <i>Cardiac failure due to atherosclerotic heart disease</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>
Antecedent cause(s) (b) <i>Heart disease</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Renal interstitial obstruction</i>	<i>4 days</i>

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
21. SUICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *4/20.0*, 19*51*, to *9/3d*, 19*51*, that I last saw the deceased alive on *7/24*, 19*51*, and that death occurred at *7:45 P.* m., from the causes and on the date stated above.

SIGNATURE <i>Thomas H. Harrison</i>	DATE THEREOF <i>1/9/51</i>	NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>	LOCATION (City, town, or county) <i>Easton Talbot Md</i>	(State) <i>Md</i>
DATE REC'D BY LOCAL REG. <i>1/8/51</i>	REGISTRAR'S SIGNATURE <i>M. A. Nevers</i>	24. FUNERAL DIRECTOR <i>Charles Stafford</i>	ADDRESS <i>Easton Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 28 1961
MAIL ROOM

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL, EASTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL, EASTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>ROSA</u> (Middle) <u>EMMA</u> (Last) <u>MARSHALL</u>		4. DATE OF DEATH (Month) <u>JAN.</u> (Day) <u>15</u> (Year) <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT. 23 1895</u>
9. AGE last birthday <u>55</u> yrs. <u>3</u> Months <u>23</u> Days		10. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>	
11. FATHER'S NAME <u>THEODORE JONES</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. MOTHER'S MAIDEN NAME <u>MARY KIRBY</u>		14. INFORMANT AND ADDRESS <u>HARVEY MARSHALL, EASTON, MD.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NINE</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH
minutes

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1-1, 1946, to 1-15, 1951, that I last saw the deceased

alive on 1-14, 1951, and that death occurred at 5:40 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>JAN. 18, 1951</u>	<u>SPRING HILL CEMETERY</u>	<u>EASTON, MARYLAND</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/16/51</u>	<u>M. H. Neer</u>	<u>John H. Williams</u>	<u>EASTON, MD.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

RECEIVED
JAN 30 1951
BUREAU 7.5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cordova</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Patricia</u> (Middle) <u>Dionne</u> (Last) <u>Plugge</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Aug 15 1950</u>
9. AGE last birthday <u>1 yr. 10 mo. 13 da.</u>		10. BIRTHPLACE (State or foreign country) <u>MD</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN, OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>J. R. Plugge</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Oglet</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mrs. J. R. Plugge</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
1. Immediate cause (a) <u>Bronchopneumonia, Whooping Cough</u>		<u>8 days</u>
Antecedent cause(s) (b) <u>Malnutrition, Congenital Malformation</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Small Intestine - operated at 5HH.</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-22, 1951, to 1-28, 1951, that I last saw the deceased alive on Jan 28, 1951, and that death occurred at 8:25 A.M., from the causes and on the date stated above.

SIGNATURE John E. Baybutt MD ADDRESS 214 Dover St Easton MD DATE SIGNED 1-31-51

23. BURIAL, CREMATION REMOVAL, (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/31/51</u>	<u>Spring Hill Cemetery</u>	<u>Easton Talbot Co</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/28/51</u>	<u>N. A. Morris</u>	<u>Carlson & Stafford</u>	<u>Easton MD</u>	

208170211404

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED BY THE SECRETARY OF THE ARMY

OFFICE OF THE SECRETARY OF THE ARMY

RECEIVED
FEB 7 1951
U.S. ARMY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Nelen</u> (Middle) <u>Lottie</u> (Last) <u>Ross</u>	4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>5</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>✓</u>	8. DATE OF BIRTH <u>Mar. 6 - 1948</u>
9. AGE last birthday <u>2</u> yrs. <u>9</u> Months <u>25</u> Days		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Perry Ross</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mary Wilson Ross Easton, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Ischemic heart</u>		<u>Normal</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE <u>accident</u> HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>home</u> INJURY	(CITY OR TOWN) <u>in Trappe</u> (COUNTY) <u>ice</u> (STATE) <u>ind</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1</u> <u>5</u> <u>51</u> <u>AM</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>shot by 19 year old brother - last year</u>

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at..... 6:30 A.M......, from the causes and on the date stated above.

SIGNATURE <u>Louis Whately M.D.</u>	(Degree or title) <u>D.M.S.</u>	ADDRESS <u>Easton Md</u>	DATE SIGNED <u>1-5-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan 6 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St Paul Church Cemetery</u>	LOCATION (City, town, or county) (State) <u>Easton, R.D.</u> <u>Md</u>
DATE REC'D BY LOCAL REG. <u>1/5/51</u>	REGISTRAR'S SIGNATURE <u>N. H. Neerius</u>	24. FUNERAL DIRECTOR <u>John D. Williams</u>	ADDRESS <u>Easton, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF AGRICULTURE
OFFICE OF THE SECRETARY
WASHINGTON, D. C.

RECEIVED
JUN 28 1951
B A OVR

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Talbot</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u>	(Middle)	(Last) <u>Shorter</u>
4. DATE OF DEATH	(Month) <u>Jan</u>	(Day) <u>11</u>	(Year) <u>1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb 1, 1885</u>
9. AGE last birthday <u>65</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Shorter</u>		14. MOTHER'S M maiden name <u>Mary Ellen Handy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Mr. Michael R. Poff</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443x Immediate cause (a) <u>Quasarcia</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Chronic Myocarditis</u>	<u>1 yr</u>
(c) <u>Hypertensive Vascular Disease</u>	<u>yes.</u>

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-5, 1957, to 1-11, 1957, that I last saw the deceasedalive on 1-10, 1957, and that death occurred at 6:05 A.M., from the causes and on the date stated above.SIGNATURE W. F. Buell (Degree or title) M.D. ADDRESS Easton Md DATE SIGNED 1-11-57

23. BURIAL CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>1/12/57</u>	NAME OF CEMETERY OR CREMATORY <u>Easton Board</u>	LOCATION (City, town, or county) <u>Balto</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>1/12/57</u>	REGISTRAR'S SIGNATURE <u>N. H. Deere</u>	24. FUNERAL DIRECTOR <u>Norman J. Marshall</u>	ADDRESS <u>St. Michaels Md. 690506</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0889 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Annie, Miss.</u>	(First) (Middle) (Last) <u>Smith</u>	4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb 10, 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Sales Lady</u>	9. AGE last birthday <u>80+</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. William E. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Jump</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Miss Margaret Smith</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral Thrombosis</u>		<u>20 hrs</u>
Antecedent cause(s) (b) <u>260X</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes mellitus</u>		<u>671</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 22 Jan, 1951, to Jan 24, 1951, that I last saw the deceased alive on 24 Jan, 1951, and that death occurred at 12 Noon, from the causes and on the date stated above.

SIGNATURE <u>Thurston Harrison M.D.</u>	DATE SIGNED <u>24 Jan 51</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Buried</u>	DATE <u>Jan 26, 1951</u>
NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	LOCATION (City, town, or county) (State) <u>Easton, Talbot Md</u>
DATE REC'D BY LOCAL REG. <u>1/25/51</u>	24. FUNERAL DIRECTOR <u>W. H. Newer</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>		LENGTH OF STAY (In this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>Winton Ave</u>	
3. NAME OF DECEASED (Type or Print)		(First) <u>Charles</u> (Middle) <u>Marmott</u> (Last) <u>Spencer</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 5 1894</u>	9. AGE last birthday <u>58</u> yrs.	If under 1 year Months If under 24 hrs. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salmon</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery, Salmon</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Alfred Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Evans</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-10-6748</u>		17. INFORMANT <u>Mrs Charles Marmott Spencer</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443x Immediate cause

(a)

Cardiac failure

INTERVAL BETWEEN ONSET AND DEATH

30 minutes

93d Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Hypertension with cardiac vascular disease3 years -

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1948, to 2 pm, 1951, that I last saw the deceasedalive on 2 pm, 1951, and that death occurred at 2:45 PM m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

RECEIVED
JAN 9 1951
S. A. DYER
•

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0891 274

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Hubert St.</u>	
3. NAME OF DECEASED (Type or Print) <u>DONNA R STANLEY</u>		4. DATE OF DEATH <u>1-5-57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>11-3-1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>6</u> yrs. <u>2</u> months <u>2</u> days
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>DANIEL STANLEY</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE E JACKSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>DANIEL STANLEY TILGHMAN MD.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Practically congenital heart condition

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Had a falling thin into well

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov 19, to Jan 5, 1957, that I last saw the deceased

alive on Jan 5, 1957, and that death occurred at 2:30 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

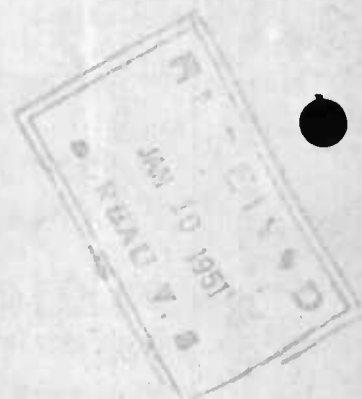
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>1-6-57</u>	<u>SHERWOOD COL</u>	<u>TALBOT CO.</u>	<u>MD.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1-5-57</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>Tilghman MD.</u>	

91X030-9000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Noltr.

11892

CERTIFICATE OF DEATH

Reg. Dist. No. *294*

1. PLACE OF DEATH- COUNTY <i>Dorchester</i> TALBOT MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Dor.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Whitman</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Fishing Creek</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>none</i>		STREET ADDRESS (If rural, give location) <i>none</i>	
3. NAME OF DECEASED (Type or Print) <i>JOHN A. TRAVERS</i>		4. DATE OF DEATH (Month) <i>Jan.</i> (Day) <i>21,</i> (Year) <i>1951</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>9/17/1878</i>
9. AGE last birthday <i>73</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>	
11. BIRTHPLACE (State or foreign country) <i>Fishing Creek, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alexander Travers</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Lewis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY No. <i>217 14 8462</i>	
17. INFORMANT AND ADDRESS <i>Mrs. Earl C. Elliott, Whitman, Md.</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Cerebral Hemorrhage*

Antecedent cause(s)

(b) *arteriosclerosis*

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 days 5 1/2 hrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Jan 20*, 19*51*, to *Jan 24*, 19*51*, that I last saw the deceased alive on *Jan 20*, 19*51*, and that death occurred at *11:40 A.M.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	DATE THEREOF <i>1/24/51</i>	NAME OF CEMETERY OR CREMATORY <i>Dorchester Memorial Park Cambridge, Md.</i>	LOCATION (City, town, or county) <i>Cambridge, Md.</i>
---	--------------------------------	---	---

DATE REC'D BY LOCAL REG. <i>Jan 22-1951</i>	REGISTRAR'S SIGNATURE <i>G. Wesley Sewell</i>	24. FUNERAL DIRECTOR <i>Le Compte Funeral Service</i>	ADDRESS <i>Cambridge, Md.</i>
--	--	--	----------------------------------

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

910126



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>Days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Md.</u> TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Martha</u> (Middle) <u>Hegmann</u> (Last) <u>Wilkins</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>13</u> (Year) <u>1951</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 23, 1893</u>	9. AGE last birthday <u>77</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>		11. BIRTHPLACE (State or foreign country) <u>Queen Anne County, Md.</u>	
13. FATHER'S NAME <u>William Thomas Hegmann</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT <u>Spencer</u> <u>Mrs. Bates Riddle</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
331x Immediate cause (a) <u>apoplexy</u>		<u>Sudden</u>
83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>arteriosclerosis, generalized</u>		<u>years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/30/1950, 1944, to 1-13-51, 1951, that I last saw the deceased alive on 12/30/1950, and that death occurred at 6 a m., from the causes and on the date stated above.

SIGNATURE PB Col (Degree or title) M.D. ADDRESS Easton, Md. DATE SIGNED 1-15-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>Jan 16, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	LOCATION (City, town, or county) <u>Easton</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>1/14/51</u>	REGISTRAR'S SIGNATURE <u>N.D. Neirius</u>	24. FUNERAL DIRECTOR <u>Edith</u>	ADDRESS <u>Edith, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 30 1951
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

8894

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Preston, Maryland</u> LENGTH OF STAY (in this place) <u>6 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Preston</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Memorial Hosp.</u>		STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print) (First) <u>John</u> (Middle) <u>H.</u> (Last) <u>Willsborough</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>5</u> (Year) <u>1951</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 16, 1864</u>
9. AGE last birthday <u>86</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE last birthday <u>86</u> yrs.
11. FATHER'S NAME <u>Thomas J. Willsborough</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	13. MOTHER'S MAIDEN NAME <u>Sallie Eaton</u>	14. INFORMANT <u>Mr. Clayton Willsborough</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 Immediate cause (a) <u>Ventricular arrest</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arteriosclerotic Heart Disease</u>	<u>years</u>
(c) <u>Benign Prostatic Hypertrophy</u>	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>Jan 5, 1951</u>	19b. MAJOR FINDINGS OF OPERATION <u>Benign Prostatic Hypertrophy</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u></u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u></u> (CITY OR TOWN) <u></u> (COUNTY) <u></u> (STATE) <u></u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>	INJURY OCCURRED White at <input type="checkbox"/> Not White At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u></u>

22. I hereby certify that I attended the deceased from 12-5-50, 1950, to 1-5-51, 1951, that I last saw the deceased

alive on Jan 5, 1951, and that death occurred at 2 p.m., from the causes and on the date stated above.

SIGNATURE B. Cof (Degree or title) 2nd D. ADDRESS Easton Md DATE SIGNED 1-6-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/8/51</u>	NAME OF CEMETERY OR CREMATORY <u>W.O.H. AM</u>	LOCATION (City, town, or county) <u>Preston Md</u> (State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>1/6/51</u>	REGISTRAR'S SIGNATURE <u>N.H. Neeress</u>	24. FUNERAL DIRECTOR <u>J.M. Stoll</u>	ADDRESS <u></u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

